TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ahmed Khalifa MD

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-15-3303-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…this request was in response to a $285.90 reduction of the $866.86 for the EMG performed on January 19, 2015."

Amount in Dispute: $285.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Regarding A4556, the supplies normally used to complete nerve conduction studies are included in the allowable for the billed nerve conduction studies. Regarding 99204. Documentation does not support the level billed."

Response submitted by: Gallagher Bassett, 6404 International Parkway, Suite 2300, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 19, 2015	95910, A4556	$285.90	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15 – Payer deems the information submitted does not support this level of service
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. What is the applicable rule pertaining to reimbursement
2. Is the requestor entitled to additional reimbursement?

Findings

1. Based on the requestor's DWC060 the only codes with amounts in dispute are 95910 and A4556. This dispute is related to professional medical services. Per 28 Texas Administrative Code §134.203 (c)

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service annual conversion factor).

The services in dispute will be reviewed as follows:

- Procedure code 95910, service date January 19, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 2 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 2.038. The practice expense (PE) RVU of 0.96 multiplied by the PE GPCI of 1.006 is 0.96576. The malpractice RVU of 0.09 multiplied by the malpractice GPCI of 0.955 is 0.08595. The sum of 3.08971 is multiplied by the Division conversion factor of $56.20 for a MAR of $173.64.
- 28 Texas Administrative Code § 134.203(b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;" Procedure code A4556, service date January 19, 2015, has a status code of P – "Bundled / Excluded Code." No additional payment can be recommended.

2. The total allowable reimbursement for the service in dispute is $173.64. This amount less the amount previously paid by the insurance carrier of $580.96 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 15, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.